

Implementation of Patient Safety Program in the Emergency Installation of H. Adam Malik General Hospital Medan

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ABSTRACT

Patient Safety Program stipulated in the Minister of Health Regulation of the Republic of Indonesia No. 11 of 2017 namely Patient Safety Standards; Patient safety goals, and 7 steps towards patient safety. 8 Contributor Factors in Patient Safety are external factors, organization and management, physical environment, teamwork, officers, tasks, patients, and communication. This study uses qualitative research with a phenomenological approach by conducting in-depth interviews of several health workers at the Adam Malik Hospital Medan. Implementation of patient identification using 2 identities and is used for confirmation before the procedure, the implementation of effective communication is done by doing readback before carrying out the procedure, aware of high alert drugs by prescribing drugs into pharmacy, then drugs are formulated by pharmacy and before being given to patients with double checks, ensuring the accuracy of location, procedure and patients by site marking on body parts and signed in the medical recording, preventing the infection of medical Reducing the risk of patients falling by giving yellow bracelets and assistance to patients. In external contributors, the regulations used by Adam Malik Hospital are adapted from the Law of the Republic of Indonesia and the Regulation of the Minister of Health of the Republic of Indonesia, organizations and management support the staff in carrying out patient safety programs, the hospital environment is appropriate but there are several facilities that must be improved, the team's work has been running without difficulties. It patient information and educating patients.

KEYWORDS

patient safety; patient safety goals; patient safety incidents

INTRODUCTION

Primum non nocere is an expression of Hippocrates in his oath which means First, Do no Harm or in Indonesian is interpreted as "first, do not hurt" but this statement has long been irrelevant with developments in the medical world, because medical errors are a difficult thing to exert. Then in 1999, the Institute of Medicine published to err is human, which in his publication explained that it was estimated that as many as 44,000-98,000 American population died annually due to medical errors. This paradigm recognizes that basically, humans make mistakes and conclude that patient safety depends on the formation of a system that can anticipate mistakes, prevent and find it before causing losses (Wachter, R.M, 2012).

According to the Regulation of the Minister of Health of the Republic of Indonesia Number 11 of 2017, all hospitals that run health services have a necessity to prioritize patient

safety. As defined, patient safety in hospitals is a mechanism that makes patient services that are held safely including risk assessment, identification, and manage matters related to risks in patients, follow-up, as well as the implementation of solutions to reduce the possibility and prevent injury events due to errors in implementing behavior or not behaving that should be done.

At present, the view of medical errors has shifted which had focused on individuals to focus on the system. In -depth investigations that have been carried out revealed that an incident occurred due to a combination of minor negligence, deficiencies and errors that occur in the organizational system. So that the 'closest' individual of the incident is often the end of a series of very long chains.

Every health service is required to carry out patient safety. In carrying out patient safety there are three main things to be applied, namely patient safety standards; Patient safety goals, and 7 steps towards patient safety. (Permenkes RI, 2017).

In the world, there are approximately 376,41-505.28 out of 100,000 population per year experiencing incidents in hospitals, higher incidents in 2017 in countries such as Australia [2232.35 (1930.15 to 2577.7)], and the United States [2629.95 (2242.94 to 3077.48)]. Conversely, countries such as Ghana [277.97 (239.81 to 315.69), India [167.26 (140.4 to 194.8) and Brazil [95.09 (83.8 to 107.53)] showed a lower level of incident. The American continent has the highest incident, which is 1,160.99 (991.66 to 1359.14), compared to the lowest incident, namely in the Southeast Asian continent [155.98 (130.7 to 182.52)] per 100,000 in 2017. (Nauman, et al., 2020).

In Indonesia, in 2019 there were 7,465 cases reported to the Ministry of Health of the Republic of Indonesia, and as many as 1,489 cases in 2018, 1,647 cases in 2017, 668 cases in 2016, and 289 cases in 2015. In 2019, as many as 38 cases reported were almost injured cases, 31% of cases were not injured, and as many as 31% of cases of unwanted events. Of the 7,465 reports received, as many as 171 cases of death, 80 cases of severe injury, 372 cases of moderate injury, 1183 cases of minor injuries, and 5,659 cases did not suffer injuries (Daud, A., 2020).

The cause of patient safety incidents is often associated with the term human-factor. According to Henriksen, there are several factors that might trigger the incident, including; Individual characteristics factors, basic characteristics of work, physical environment, interactions between humans and systems, organizational/social, and management. Carayon and Smith argue that there are 5 factors namely humans, technology and devices, physical environment, organizational goals, and service processes. Meanwhile, according to Vincent there are 6 factors that influence, including; Patient characteristics, work factors, individual factors, team factors, work environment, and organizational factors, and management factors.

Emergency installation is a complex, dynamic, and very vulnerable room to the occurrence of patient safety incidents. Emergency conditions, a short time for critical thinking, can cause delays in decision making so as to increase the risk of incidence. The results showed that almost one in 10 people who were hospitalized experienced a traumatic event that was about half of them to be prevented. It also according to the estimates made, 3% of all hospital errors are related to emergency wards. As well as traumatic events in about 10% of patients with surgery that are more common in the emergency department (Ahwal, S. N., 2015; Amaniyan, S., Faldaas, B. O., Logan, P. A., & Vaismoradi, M. 2020).

It is estimated that as many as 60% of the patient's safety incident in hospitals originated from the Emergency Department (Patanwala, A. E., Warholak, T. L., Sanders, A. B., & Erstad, B. L., 2010). Many emergency installations cause patient safety incidents due to several factors, including the complexity and variability of patients, worker factors (fatigue,

lack of education and competence, and behavior take high risk), doctors' relationships, work environment, and other factors (multicultural patients/ multicultural). As many as 29% of doctors have reported that the occurrence of patient safety incidents caused by a poor hand-off process (Horowitz et al., 2009). Re-visit to the emergency department in a period of 7 days, as many as 12% was caused by a patient safety incident (Calder L., Pozgay A., Riff S et al., 2015).

Based on the results of a preliminary survey conducted at H. Adam Malik Hospital Medan, in 2021 there were a total of 15,314 patients who underwent hospitalization in the Hospital of the Hospital of H Adam Malik Medan. In 2021, there were 531 reports on the patient's safety incident 453 cases including a case of potential injury, 49 cases were almost injured, 25 cases of incidents were not injured, and 9 cases of unexpected events. The number of nurses on duty at the Central Hospital of H Adam Malik Medan is 706 people.

To identify the implementation of the Patient Safety Program Emergency Installation at the Central Hospital of H Adam Malik Medan.

RESEARCH METHODS

This research is a qualitative study with the phenomenological approach of a qualitative research approach which aims to multiply a facts that occur, individual behavior, or groups and factors that underlie feelings, opinions, events, relationships, and others. The research informant in this study consisted of all officers on duty at the Emergency Installation of the Central Hospital of H Adam Malik Medan, the Triase doctor as many as 15 nurses were 123 people, the resident doctor who served in the emergency room, the head of the emergency room in the Hospital of the Central Hospital of H Adam Malik Medan, and the Safety Committee of the Central Hospital of Hospital H Adam Malik. The municipalization is through primary and secondary data. Primary data is obtained using the In-Depth Interview method or in-depth interviews guided by interview guidelines that contain questions related to research topics. The interview process will be recorded using a recorder so that there is no wrong or missed information. Researchers also observed the situation that occurred at the research site and recording and tense with the help of observation sheets. Secondary data obtained from hospital data, namely the data of patient safety incidents that occur at the study site. Data analysis in this study was carried out interactively, which went continuously to the end and the data became saturated. The interactive method is carried out by going through several processes, namely data collection, data reduction, data presentation, and adding conclusions/verification carried out continuously.

RESULTS AND DISCUSSION

Patient Safety

The patient identification was then asked back to the Head of the Emergency Room of the Emergency Installation of the Central H. Adam Malik Medan General Hospital. The results of the interview are outlined in the description below.

Table 1. Patient Identification

Interview Results	Observation Results
The patient uses the patient's identity bracelet in accordance with the sex of the patient containing the patient's name data, date of birth, date of entry. patients and medical record numbers.	The bracelet is installed in the patient's hands according to the sexes, namely pink in female patients and blue bracelets in male patients containing information on the name, date of birth, time to enter the patient and the patient's medical record number

Based on the results of the interview, it can be seen that the health worker on duty at the Emergency Department has carried out the identification of patients marked by the implementation of the installation of the patient bracelet. The patient's bracelet consists of 2 types based on sex. Female patients use pink bracelets while male patients use blue bracelets. This bracelet contains the patient's identity, the identity consists of the patient's name based on the patient's identity card, the patient's birth date, the patient's age, the medical record number, the population registration number, the barcode, and the inpatient entry date.

The identity in the bracelet is then used by health workers to confirm the patient's identity each will be given services such as providing drugs, blood collection, or other medical measures.

Patient identification aims to ensure that the patient is the right patient for a procedure that has been previously planned and aims to match the procedure set to the patient. This policy is determined to identify patients when given drugs, given blood products, taking blood specimens, or other specimens for the purposes of diagnosis or clinical examination, as well as giving other actions or management.

Based on data obtained from the quality indicators of clinical services priority H. Adam Malik Medan Hospital in 2022, the implementation of compliance with patient identification in January-September was 100%, namely the officers had identified the patient before providing services.

The procedure carried out in the patient identification process requires at least 2 patient identities, namely the name or date of birth, the medical record number and the bracelet of identity in a variety or other. Things that cannot be used in identifying patients are the location of the bed and the patient's room number. The patient identification process is carried out with the following (Regulation of the Minister of Health of the Republic of Indonesia, 2017.):

1. Identifying patients with 2 identities, not using room numbers and the patient's location.
2. Identifying patients before administering drugs, blood, or blood products.
3. Identify the patient before taking blood specimens or other specimens in the interests of clinical examination
4. Patients are identified before being given action or prosecutor
5. Implementation of identification is directed to be consistent in all locations and conditions.

Champaca's research in Banjarmasin stated that of 107 respondents as many as 69 people (64.5%) had carried out the patient identification well, while 38 others (35.5%) were still in the lack of category (Nursery, S, 2023). Soru's research in 2018 also stated that as many as 100% of health workers were compliant in carrying out the identification of patients both before giving treatment, and confirmed the identity of the patient using 2 types of identity, but only 1 respondent did not carry out the accuracy of the patient's identification before taking the specimen (Soru, AR A., and Wahyuningsih, A., 2018)

Effective communication is the second patient safety target. The implementation of effective communication at the Emergency Department Installation is described in the results of the interviews below:

Table 2. Effective Communication

Interview Results	Obsevation Result
<ul style="list-style-type: none"> - Storage of high alert drugs is in pharmacy - High alert drugs are labeled lasa - Double check before giving the drug to the patient 	<ul style="list-style-type: none"> - Emergency installation has its own pharmaceutical depot so that if there is a request for high alert drugs it will be addressed to the IGD pharmacy depot for preserving.

	<ul style="list-style-type: none"> - High alert medicines have a label Lasa in every ampoule or drug packaging. - Before administering the drug to the patient the officer re -ensures the patient's identity and asks fellow officers to re-ensure.
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Examples of drugs whose use need to be watched out for are drugs that have NORUM (names of drugs, appearance and similar greetings) or commonly known as LASA (look-alike-sound-alike) drugs. The error in administering this NORUM drug if it occurs is feared can provide a high risk of incidents or unwanted events.

Efforts made in aware of the use of these drugs are by setting the identification process, location, labeling, and storing drugs that need to be watched out, implementing the policies and procedures that have been set, drugs such as electrolytes concentrated highly stored in different places from the place of service, if stored in the patient service unit (Eisenberg, E., Murphy, A., Sutcliffe, K., Wears, R., Schenkel, S., Perry, S., & Vanderhoef, M., 2005)..

Description of the exact certainty of location, procedure, and surgery patient. The fourth patient safety target component is to ensure the location of the correct surgery, the correct procedure, and surgery in the correct patient. The picture of the target can be seen in the interview below;

Table 3. The Identification Process, Location, Labeling, and Storing Drugs

Interview Result	Observation Result
Site marking was carried out in the patient's body and signed in a medical record.	The officer gave a sign in the patient's body who had two sides with a circle mark and then also depicted in the patient's medical record and signed by the officer, the patient, and the witness.

Some activities that can be carried out in the process of ensuring the accuracy of the patient, procedures and location of this surgery can be done by using a checklist or other methods in verifying for a moment before surgery to ascertain whether or not the location, procedures, and patients, and all documents and equipment that will be needed are available, precisely and functioning properly, the team that will perform surgery perform and record procedures before the incision (time out) Operating Room (Ministry of Health of the Republic of Indonesia, 2017).

According to Suryathi, Sukmandari, and Wulandari (2021), from the extent of 31 research samples, nurses' compliance in running timeouts of 70.9% and nurse knowledge rates 77.4% in the good category. A positive relationship is found, namely the level of knowledge and compliance of nurses in conducting timeouts. Saputra, et al (2022) research states that there is a significant relationship between education, knowledge and training factors to the implementation of Surgical Safety Checklist. Workload has no relationship with the application of Surgical Safety Checklist

Description of the implementation of efforts to reduce the risk of infection due to health care. Activities that can be carried out in preventing patient safety incidents one of which is to reduce nosocomial infection efforts. The description of the implementation of the target is described in the following interview.

Table 4. Efforts to Reduce the Risk of Infection Due to Health Care

Interview Result	Observation Result
Wash hands five moments using soap or hand rub	<ul style="list-style-type: none"> - There is a sink that functions in the emergency department and soap that has contents - Available handrub on each side of the patient's bed - Found a banner how to wash hands near the emergency sink

Infections in health services associated with treatment are urinary tract infections due to the use of catheters, blood flow infections, and respiratory infections or pneumonia. The essence of infection prevention infection is to carry out hand hygiene. According to the Minister of Health Regulation of the Republic of Indonesia No. 11 of 2017, the efforts that can be made are to adapt the latest hand washing guidelines issued by WHO, implement the Hand Hygiene program, and develop policies to reduce the risk of infection related to services in health facilities (Kemenkes RI, 2017).

Based on Hidayah and Ramadhani's research, health workers' compliance with 5 moments of washing hands is 56% nurses, 53.37% in midwives, and 49.33% at doctors. The compliance before contact with patients is 55.81%, before the aseptic action of 56.41%, after exposure to body fluids at a risk of 70.11%, after contact with patients 53.16% and after contact with the patient's environment of 27.27% (Hidayah, N., & Ramadhani, N P., 2019).

Some factors that are able to support the implementation of the Hand Hygiene program are the availability of facilities and infrastructure, as well as management support. Things that hinder the implementation of hand hygiene are the high workload of nurses, lack of concern, lack of understanding, and demands for efficiency (Wijaya, H., Novitasari, S. Jubaidah. 2018). Ritonga's research in Medan stated that the implementation of 59% hand hygiene was still not good, while the rest was still not good (Ritonga, 2017). Other studies state that the factors that influence hand hygiene compliance are the working period of (p: 0.033) (Pundar, 2019).

The implementation of the target reduction in the risk of nosocomial infection is done by washing hands either with soap or with handrub. This is in accordance with the regulations stipulated in the Regulation of the Minister of Health of the Republic of Indonesia.

Overview of the implementation of risk reduction of patient injury due to falling. The sixth patient safety target is an effort to reduce the risk of falling patients. The results of in - depth interviews on this matter are:

Table 5. Risk Reduction of Patient Injury due to Falling

Interview Result	Observation Result
<ul style="list-style-type: none"> - Discreening patients have the risk of falling. - Patients at risk of falling will be given a yellow bracelet. 	<ul style="list-style-type: none"> - Patients who have the risk of falling using a yellow bracelet. - Patients are positioned in an easily visible location from Nurse Station. - In patients who are at risk of falling the bed will be lowered and the bed bar will be installed.

The number of cases of patients falling in health services is something that needs to be considered in the hospital treatment process. The steps that can be taken in reducing the patient's risk of falling patients are with the initial assessment of the presence or absence of the risk of the patient to fall and reassessment if there is a change in the patient's condition or treatment of the patient, taking action to reduce the risk of falling for patients at risk.

Efforts are also carried out by lowering the bed, installing the bed bar and assistance to patients at risk.

Some of the factors that influence nurses' compliance in preventing patients from falling are the knowledge and attitudes of nurses. Age, gender, marital status, working period, education and supervision do not have a relationship with the implementation of the patient risk program for the hospital.

Contributors and Patient Safety Incidents

External factors for patient safety incidents. External factors are contributing factors for patient safety incidents originating from outside the hospital. This factor can be in the form of regulations, economics, laws and government policies or relationships to other related organizations. The picture of the external influence of the hospital is described in the interview below.

"Adam Malik's internal regulation from outside it was a basis for determining internal regulations, from Article 44 of 2009, Minister of Health Regulation No. 11 2017, Minister of Health Regulation No. 80 2020 concerning the Quality Committee, KMK 1128 PMKP, it becomes the basis for determining our internal policy, well, that we establish the RSHAM quality policy, derived to be a guideline, then become a program, then become a SPO, so as a basis for establishing Adam Malik's internal regulations, adjusted to the conditions in the hospital, for example in the Minister of Health it is mentioned that the patient's sub-salvation must

Based on the results of interviews above the health workers stated the importance of regulations regarding patient safety which can help direct the task so as not to make mistakes. Regulations stipulated at the Central Hospital of H Adam Malik are guided by regulations issued by the state, including Article 44 of 2009 Law, Permenkes N0 11 of 2017, Permenkes No. 80 of 2020, and Kepmenkes No. 1128 of 2022.

Patient safety is the business of all people and requires active participation from many main partners ranging from patients and their families to government, non-governmental, and professional organizations, including the government, namely the Ministry of Health and its executive institutions at the national and regional levels, legislative institutions, other related ministries, and regulatory agencies; Health facilities and services where all health service facilities ranging from health center to large education hospitals, regardless of ownership and scope of services; Stakeholders are non-governmental organizations, patients and patient organizations, professional and community and community associations, academic and research and civil society organizations; and WHO namely WHO at all levels of state offices, regional offices and head offices.

Organizational and management factors of patient safety incidents. In organizational and management factors there are several components including organizations and management, policies, standards and objectives, administration, patient safety culture, human resources, and training. Organizational and management components include organizational structure, supervision and decision making in the patient safety program that runs in the emergency department. In this component will be discussed about how leaders provide support to the staff and how the role of the leadership in the patient safety program.

"The role of the leader besides monitoring also educates if for example KNC things happen. At certain times there are meetings such as accreditation there are re-education about the SKP but if there is no daily. In the past when the old director of the SKP (Patient Safety Target) was read the same time for apple. "

Based on the description of the results of the interview above, the role of superiors in preventing patient safety incidents is to provide support and motivation to health workers on

duty at the emergency room. These supports are also realized by providing instruments that can support the implementation of services and patient safety programs with a banner. The boss also facilitated education of health workers by conducting education, meetings and seminars.

Based on the patient safety cultural survey conducted by H Adam Malik Hospital Medan in 2022 stated that in the respondent's perception when doing work according to the patient's safety procedure will receive praise from superiors from 393 respondents 14% strongly agree, 76% agree, 9% disagree and 1% strongly disagree.

According to Mustika et al's research, there was a significant relationship between the support of nursing management and the quality of patient safety services and the direction of positive relationships and with a strong relationship. This means that the better the support of nursing management, the better the quality of the patient's safety services. (Mustika et al., 2021). Mardiani's research, the leadership played a role in efforts to improve patient safety with appropriate decision making as well as with standards and criteria for leaders in improving patient safety (Mardiani, 2019).

Work environment factors for patient safety incidents. This contributor factor will discuss building design including building functionality and maintenance as well as how the completeness of infrastructure and maintenance facilities.

"Until now, if the building is definitely feasible, for maintenance we submit it to the management, this is a government hospital, as long as there are no findings such as leaking air conditioners, mossy or moldy ceilings, bathrooms, we report it. We report all the findings, damaged doors are made maintenance "

Based on the results of the interview above, there are several informants who stated that the building was feasible, and several others felt the building was not feasible. Maintenance of infrastructure is generally carried out if there are reports from the emergency room regarding damage. Flooding and leakage due to rain is the most often found and quite disturbing in the emergency room, but if it is reported the janitor immediately comes and clean the area that occurs inundation.

Calibration of medical equipment is carried out on a scheduled manner by external parties. This calibration is carried out on all medical equipment in the hospital environment. Medical devices carried out calibration will be recorded the last date is carried out and attached or hung on the medical device.

Completeness of facilities and infrastructure is a crucial thing in the running of the patient safety program. Uncertainty of certain equipment can hamper services and even trigger patient safety incidents that can be detrimental to both hospitals and patients. Requirements for building techniques and infrastructure in hospitals have been documented completely in the Minister of Health Regulation of the Republic of Indonesia Number 24 of 2016.

Team contributor factor. The complexity of tasks in health services requires contributions from various individuals and various professions, so teamwork is needed. Team work is one of the contributor factors in the patient safety incident. The components of team work are supervision and consultation, consistency, leadership and responsibility, as well as responses to incidents. The description of the interview regarding teamwork is as follows.

"The obstacle that can occur is for example in the emergency room because the patient is too booming, for example the patient comes from the internal disease section that the completion of 1-2 hours, for example there are obstacles in the lab, it has extended the results of the completion, so for 3-4 hours the patient is stuck at the emergency.

Based on the description of the interview above, the team's work is done by helping fellow health workers, at certain times when certain labels are there are no patients, nurses who are responsible for the label will help the task of nurses on other labels. The difficulty that

generally occurs is when there are too many patients and there are obstacles in other installations that can slow the flow of patient services.

A team is defined as a group that can be identified from two or more people who work on a depending way to common goals that cannot be achieved effectively if done alone. Team work refers to behavior (for example, communicating and sharing information, checking mutual understanding), attitudes (for example, trust in team collective abilities and the need for teamwork), and cognition (for example, mental models together) used by the team to communicate.

Contributor Factors Officers. Contributors of officers in the context of patient safety explain how qualifications, knowledge and labor skills, as well as motivation, and stressor both mental and physical. Description of the interview regarding the task contributor listed below.

"If you are tired of sure, let alone tired, even in a powerful condition we can make mistakes so especially in the condition of fatigue. But as far as I know the IGD coordinator has made workflow in such a way that no one is overwork, the shift settings are the best. "

Based on the results of interviews above the staff at the emergency room feel fatigue is a common thing, but the arrangement of work shifts that have been arranged in such a way as to overcome these fatigues. Staff realizes that in a state of fatigue or not tired the incident is inevitable. The number of patients who come and lack of energy in the emergency room also generally occur, causing fatigue.

According to the informant, during the afternoon shift will generally be crowded with patients who come due to new until referred from the previous hospital. In the afternoon will usually be crowded with patients so that often the officers feel overwhelmed by the crowd of patients. According to the calculation of the need for the number of nurses based on the formula of the Ministry of Health of the Republic of Indonesia with an average number of per shifts visits of 20 patients, the duration of service per patient averaged 4 hours and the duration of the work shift of 6 hours per shift, then the ideal number of officers obtained was 13-15 people. Based on these calculations, the number of officers working at the Emergency Room Installation is currently less than the amount that should be 8 officers per shift.

Good staffing management will affect organizational performance. And functions for the preparation of personnel so that each officer gives maximum effort to the organization and has an impact on interrogating strategic shocks and the allocation of appropriate human resources, increasing the effectiveness of nursing management with appropriate information to direct changes, obtain labor that gives maximum use to the organization, systematic scheduling patterns, and developing nurses' abilities and skills in hospitals.

Task Contributor Factors. Task contributors include explaining the availability of standard operational procedures (SPO) in hospitals. The description of the interview regarding the availability of SPO is as follows.

"Our SPO is there, not stored, there is in (room) service, even every morning we briefing please 1 day read 1 SPO. Especially in the emergency room, everything is good covid, TB, emergency room, all complete is provided "

The results of the interview above stated that the SPO is available and in the hospital and the SPO is easy to access. SPO can be found anywhere, both at the table around the emergency room and also listed on the service computer at the emergency room. SPO can also be accessed via a mobile phone that makes it easy for staff to read.

Recommendations that have been translated into guidelines are the best proof -based solutions for clinical practice problems. However, it seems that there are only a few clinical guidelines that focus on patient safety, especially in the risk management sector. In addition, when using clinical guidelines for improving quality and security, practice often seems

deviant. Consequently, clinical practice that is higher quality and safer is difficult to achieve, distributed, and promoted.

Recommendations help users of guidelines for making the right decisions about whether to conduct certain interventions or clinical trials, or whether they must apply more broad public health steps, as well as where and when to do it. Recommendations also help users to choose and prioritize various potential interventions. Agency for Healthcare Research and Quality (AHRQ) also uses the definition of clinical practice guidelines developed by IOM, which states that "Clinical Practice Guidelines are statements that include recommendations intended to optimize patient care informed by a systematic review of evidence and assessment of benefits and dangers of alternative treatment.

Patient Contributor Factors. Not only health workers, some conditions that can contribute to patient safety. Some components in patients are the physical condition of the patient, the personal condition of the patient both in terms of personality, language, social and family conditions, treatment, medical history, and the relationship of staff with patients.

"If the problem of communication in the language, there are patients who do not understand Indonesian but usually there are families who can speak Indonesian. The solution is usually we are looking for a translator. "

The results of the interview above stated that some patients whose consciousness declined due to trauma had a more nervous condition and had the potential to fall, so that it was given tighter supervision with guard. Obstacles that are often experienced related to communication to patients or families of patients who generally come from outside the city of Medan and cannot speak Indonesian, so it is necessary to find translators who can help in communication.

There are several conditions in which patients have an increased risk of danger so that it can be a means to promote patient safety through improving health care processes and systems. Patient factors are one of the factors that produce conditions that contribute to incidents.

Communication Contributor Factors. The last contributor is communication, this section will discuss how the communication process carried out by health workers to patients and between medical staff. The interview description is as follows.

"Usually we do to compos mentis patients, or to the family, we speak politely, and what we convey is expected that the patient's family understands, if we nurses the goal to get to know each other, ask for approval such as giving injection, if the lab officer is to take blood samples, the main purpose is to convey information to patients"

Based on the results of interviews above the communication of health workers related to services in the emergency room is carried out to compos mentis patients or in fully aware patients. Patients who are unconscious are usually carried out amnesia to the family or who accompany the patient to explore information related to the patient's condition. Communication is not only to explore information but also to build relationships and trust in health workers. Communication is also carried out to educate patients related to information that needs to be known by the patient or patient's family. Health workers generally use ordinary language that can be understood by patients to reduce the risk of miscommunication.

Communication throughout the patient's interaction with a health care system, including during diagnosis, treatment, and transition to other treatments including at home, helps ensure patients and family nurses can participate effectively in care and make decisions based on information obtained. When this communication is not optimal or completely missed, there is an opportunity for incidents. For example, a study found that during the diagnosis process in the Emergency Unit (ER), 23% of patients did not receive an

explanation of their health problems when returning home, and a quarter of the patient did not understand the next step after leaving. ER, including what to do if the conditions deteriorate or do not improve. This type of communication disorder can cause bad events and dangerous consequences.

According to Maulidia and Damaiyanti's research, poor communication can have a negative impact on patient safety in the emergency room, and effective communication has a positive impact on patient safety (Maulida & Damaiyanti, 2021).

Based on the description above communication has the potential to cause patient safety incidents if not done properly. Health workers in the emergency room communicate with patients who are fully aware or with the patient's family or who accompany to explore the patient's condition. Health workers provide education related to the patient's condition and information that needs to be known by the patient. Communication using language that is easily understood for patients can reduce the potential for information errors. Good communication can reduce the risk of patient safety incidents.

CONCLUSION

1. Implementation of the patient safety program at the Emergency Installation of the General Hospital of H Adam Malik Medan is:
 - a. Implementation of Patient Safety Targets at the Emergency Installation of the Hospital of the Hospital of H Adam Malik Medan:
 - Implementation of patient identification is in accordance with the Regulation of the Minister of Health of the Republic of Indonesia Number 11 of 2017 concerning Patient Safety
 - The implementation of effective communication is in accordance with the Regulation of the Minister of Health of the Republic of Indonesia Number 11 of 2017 concerning Patient Safety
 - Implementation of vigilance on high alert drugs is in accordance with the Regulation of the Minister of Health of the Republic of Indonesia Number 11 of 2017 concerning Patient Safety
 - Implementation of the right certainty of location, procedure, and operating patient is in accordance with the Regulation of the Minister of Health of the Republic of Indonesia Number 11 of 2017 concerning Patient Safety
 - Implementation of efforts to reduce the risk of infection due to health care is in accordance with the Regulation of the Minister of Health of the Republic of Indonesia Number 11 of 2017 concerning Patient Safety
 - Implementation of patient injury risk reduction due to falling in accordance with the Regulation of the Minister of Health of the Republic of Indonesia Number 11 of 2017 concerning Patient Safety
 - b. Contributor factors for patient safety incidents are:
 - External factors for patient safety incidents are guided by regulations issued by the state, including the Law of the Republic of Indonesia Article 44 of 2009, Regulation of the Minister of Health of the Republic of Indonesia No. 11 of 2017, Regulation of the Minister of Health of the Republic of Indonesia No. 80 of 2020, and Decree of the Minister of Health of the Republic of Indonesia No. 1128 of 2022.
 - Organizational and management factors of patient safety incidents are described with the support of superiors towards staff, the culture of patient safety which

states that there is awareness, good reporting flow and education and training in the form of orientation.

- Working environment factors for patient safety incidents, namely hospital buildings, are found slippery floors due to rain that are feared to have the potential to cause patient safety incidents
- The team's work factor for patient safety incidents has been running without any significant obstacles
- Officers' factors for patient safety incidents are the lack of energy in the emergency room due to the crowd of patients who have the potential to cause patient safety incidents.
- The task factor for patient safety incidents is SPO available in the hospital environment and is easy to access
- Patient factors for patient safety incidents Some patients who influence the implementation of patient safety such as patients who decrease consciousness and anxiety so that the potential is injured
- Communication factors for patient safety incidents Communication of health workers related to services in the emergency room is carried out to compositis patients or in fully aware patients. Patients who are unconscious are usually carried out anamnesa to the family or accompanying. Communication is not only to explore information but also to build relationships and trust in health workers.

Suggestion

1. Improve infrastructure in the hospital emergency room environment to minimize patient safety incidents.
2. Re-evaluating the number of health workers on duty at the Emergency Room Installation by considering the large number of patients coming to the hospital so that services become more optimal and minimize the potential for patient safety incidents.

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